Illinois Standard Health Employee Application for Small Employers

INSURER USE ONLY

Policy/Group No.

Section No.

Effective Date

New Hire Waiting Period

For assistance in completing this application, please contact your employer or insurance agent. For information about your health insurance rights under state and federal law, and other resources, please contact the Illinois Department of Insurance's Office of Consumer Health Insurance toll free at (877) 527-9431.

This standard application is intended to simplify your health insurance application process. You will only need to complete this one application, even when your employer has requested quotes from multiple insurance companies.

The information you provide in this application will be sent to the following insurance companies:
(To be completed by employer)

Insurer: ______________________________ Insurer: ______________________________ Insurer: ______________________________
Insurer: ______________________________ Insurer: ______________________________ Insurer: ______________________________

TO BE COMPLETED BY EMPLOYER

Employer Name: | Phone #:

Address:

Reason for Enrollment (Mark all that apply)

New Enrollment: ☐ New Group ☐ Open Enrollment ☐ New Hire (Date: __________________________) ☐ Late Enrollee

Special Enrollment: ☐ Adoption ☐ Court Order ☐ Dependent Addition ☐ Divorce ☐ Domestic Partner
☐ Loss of Coverage ☐ Marriage ☐ Newborn ☐ Other Date of Event: ________/_________/_________

Employment Status: ☐ Active ☐ Retiree (Retirement Date: _______/_______/_______)
☐ Illinois Continuation ☐ COBRA
☐ Employee ☐ Dependent
Qualifying Event: ______________________________
Start Date _______/_______/________ Projected End Date _______/_______/________

A Employee Information

Name (Last) | (First) | (MI)

Job Title: | Hire Date: | Hrs/Week:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Domestic Partner

Home Address: | Apt #:

City: | State: | Zip:

Home (or Cell) Phone: ( ) | Business Phone: ( )

Email Address (optional):

B Coverage Requested

Medical

Employee: ☐ Yes ☐ No Plan Choice:	Spouse/Domestic Partner: ☐ Yes ☐ No Plan Choice:	Child(ren): ☐ Yes ☐ No Plan Choice:

If you are **waiving (declining)** coverage for yourself or any member of your family, you must complete Section C below.

GARRETT-EVANGELICAL THEOLOGICAL SEMINARY
Waiver of Group Health Benefits

Employee Name and Title

Employee Social Security Number

For the plan year effective November 1, 2018, I am waiving coverage for:
Myself
Spouse
Dependent
If selecting dependents, please list their names

I am waiving coverage due to:
My preference not to have coverage
Coverage under my spouse's/domestic partner's plan
Coverage under my parent's plan
Other coverage
Other coverage is
Employer-sponsored group plan   Individual Policy   Medicare   COBRA   TRICARE   Medicaid

Note that after 2013, if you decline coverage considered affordable and minimum essential under Patient Protection and Affordable Care Act ("ACA"), you **will not qualify** for government credits and subsidies to purchase individual health insurance on the Marketplace.

Th decision to waive coverage has consequences for you. For Example:

- You should be aware of the individual responsibility requirement taking effect in 2014 under the ACA. If you refuse the offer of the Employer's health coverage and do not obtain coverage on your own, you will be subject to a penalty.
- Unless you sign a waiver stating that they are covered under another lan, such as a spouse's plan, Medicaid, or Medicare, you cannot enroll in the Employer's health plan until the next open enrollment. However, if you are covered under another plan, but the coverage is lost, you can enroll in your Employer's health plan immediately. There's a time limit for enrolling after the other coverage is lost: you must request to enroll in your plan within 30 days of losing the other coverage.
- If you gain a new dependent through birth, adoption or marriage, you may also enroll yourself, the new dependent, and the entire family at that time, but you must do so within 30 days of gaining the new dependent. If you miss the 30-day enrollment deadline, you must wait until open enrollment.

I acknowledge that the Employer has offered me affordable minimum essential coverage, as defined under ACA, for the period from November 1, 2018 to October 31, 2019. I have read the above and I understand the consequences of my waiver of coverage.

I understand that in order to request special enrollment ot obtain more information, I should contact my group administrator.

Employee Signature   Date

Employer Name ______________________________ Employee Name ____

D Individuals Requesting Coverage

List yourself and all eligible family members to be included under coverage.

- Please check with your employer or insurance agent about who may qualify as an eligible family member under the policy.
- Illinois' Young Adult Dependent Coverage law allows parents to cover children up to the age of 26, and up to age 30 for military veteran dependents, regardless of whether the child may be considered a dependent for tax or other purposes. For more information, please visit the Illinois Department of Insurance website at www.insurance.illinois.gov.

Note: For purposes of this application, an "eligible military veteran" is a veteran who served in the active or reserve components of the U.S. Armed Forces, including the National Guard, and who received a release or discharge other than a dishonorable discharge.

If additional space is required, please attach a separate sheet and be sure to sign and date that sheet.

Employee Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

Spouse/Domestic Partner Name (Last) ________________________ (First) ________________________ (MI) ______

Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No		
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No		
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______

Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No		
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

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Employer Name ______________________________ Employee Name ____

Dependent Name (Last) ________________________________ (First) ________________________________ (MI) _______		
Social Security Number:		Date of Birth: / /
Weight: lbs.	Height: ft. in.	Gender: ☐ Male ☐ Female
Eligible Military Veteran: ☐ Yes ☐ No		
HMO only (if/when applicable): Primary Care Physician:		Physician ID:

Medicare: If you or any family members listed on this application have Medicare coverage, please complete the following information.

Enrolling Individual Name (Last) ____________________________ (First) ____________________________ (MI) _______

Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: _________/_________/_________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

Enrolling Individual Name (Last) ____________________________ (First) ____________________________ (MI) _______

Medicare ☐ Part A ☐ Part B ☐ Part D
Effective Date: _________/_________/_________
Reason for Medicare Entitlement: ☐ Age ☐ Disability ☐ ERSD ☐ Dual Enrollment

Medicare Number (please include alpha prefix):

Employer Name ______________________________ Employee Name ____

I Acknowledgement & Signature

I understand, agree, and represent that:

- I have read this document or it has been read to me.
- The answers provided within this entire application for coverage are, to the best of my knowledge and belief, true and complete.
- Neither my employer nor the agent has the authority to waive a complete answer to any question, determine coverage or insurability, alter any contract, or waive any of the insurance carrier's other rights and requirements.
- I understand that if I intentionally omit or provide false information on or in relation to this application, then this policy may be cancelled retroactively, in which case any claim I submit may not be paid by the insurer. I understand that if I intentionally omit or provide false information on or in relation to this application that I may face legal liability, including legal action based on fraud.
- If this application for coverage is accepted, coverage will be effective on the date specified by the insurance carrier on the certificate of coverage/certificate of insurance.

I hereby enroll for benefits as indicated in Section B and Section H of this application, for which I am presently eligible or for which I may become eligible under my employer's group contract(s). If any deductions are required for this coverage, I authorize such deductions from my earnings. I reserve the right to revoke this deduction authorization at any time upon written notice.

I understand that the information I have provided in this application will be used by the insurance carrier and its affiliates to make decisions regarding eligibility, enrollment, underwriting, and premium risk rating.

I understand that the medical information provided also includes my spouse/domestic partner and/or dependents' information.

I understand that I may be asked for authorization to disclose my medical, claim, or benefit records at a later time.

I understand that I should retain a duplicate copy of this application for my own records.

A photographic copy of this acknowledgment shall be as valid as the original.

I authorize the insurance carrier to electronically transmit the information contained herein.

If this application was taken over the phone or on the computer, I acknowledge that I, myself, have not actually signed this application but instead hereby authorize the insurance carrier to print "Electronically Acknowledged" on the signature line of the application and I agree that such printing shall be treated as a valid signature for all purposes of this form. I acknowledge that the insurance carrier has verified my identity for this purpose in accordance with any applicable law or regulation.

By signing below, I acknowledge that I have read and understand this document and I am signing of my own free will.

Employee Signature ____Date ________________________

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